Congress on August 30, 1954, and the New England Board of Higher Education was created as the interstate agency to carry out the mission of the compact.

In 1957, the New England Board of Higher Education established what has become its flagship program, the New England Regional Student Program, to enable New England residents to pay reduced tuition at out-of-State public colleges and universities in the region when they enroll in degree programs not offered by their home State.

The six New England States agreed in the compact to provide needed, acceptable, efficient educational resources and facilities to meet the needs of the New England workforce in the fields of medicine, public health, science, technology, engineering, mathematics, and other fields of professional and graduate training. Access and affordability have become the hallmark of the Regional Student Program of the New England Board of Higher Education.

The New England Board of Higher Education has, over the course of the last 50 years, saved New England students and their families millions of dollars in annual tuition bills. The New England Board of Higher Education provides professional development training to prepare the region's high school teachers and college faculty to teach in the fields of math, science and technology for thousands of New England's middle, high school and college students.

The Excellence Through Diversity program of the New England Board of Higher Education provides an academic support network to inspire, inform and motivate underrepresented high school students to apply to college, performs research relating to underrepresented groups enrolled in science, technology, engineering and mathematics programs in New England, and supports efforts to increase the number of minority doctoral scholars at New England colleges and universities.

Connection: The Journal of the New England Board of Higher Education is America's only regional magazine on higher education and economic development that provides a key policy forum for New England educators, business leaders, and policymakers to share best practices and current views on higher education and economic development.

For the past 50 years, hundreds of New England's leading citizens in government, education, and business have served as delegates to the New England Board of Higher Education to encourage regional cooperation, increase educational opportunities for residents of the region, and strengthen the relationship between higher education and the region's economy.

We join to congratulate the New England Board of Higher Education on the occasion of its 50th anniversary, and commend the New England Board of Higher Education for its service to New England residents and its commitment to excellence in higher education, and in particular, its distinguished Board of Delegates led by the Honorable Louis D'Allesandro of New Hampshire and its president and CEO, Dr. Evan S. Dobelle of Massachusetts.

LOCAL LAW ENFORCEMENT ENHANCEMENT ACT OF 2005

Mr. SMITH. Mr. President, I rise today to speak about the need for hate crimes legislation. Each Congress, Senator KENNEDY and I introduce hate crimes legislation that would add new categories to current hate crimes law, sending a signal that violence of any kind is unacceptable in our society. Likewise, each Congress I have come to the floor to highlight a separate hate crime that has occurred in our country.

In September of 2004, two transgender women were attacked by a group of six or seven teenagers in Washington, DC. One of the women, Kerri Kellerman, suffered two broken ribs, a fractured skull, and a facial wound requiring 40 stitches after being beaten with a brick and a metal padlock. The other woman, a 25-year-old named Jaimie Fischer, reports that the assailants yelled slurs about the victim's sexual orientation during the attack.

I believe that the Government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act is a symbol that can become substance. I believe that by passing this legislation and changing current law, we can change hearts and minds as well.

ETHA AND DRUG-RESISTANT HIV STRAINS

Mr. SMITH. Mr. President, I discuss a rare strain of HIV that is highly resistant to most antiretroviral drugs and causes a rapid onset of AIDS that was recently discovered in a patient in New York City. The strain, identified as 3–DCR HIV, is resistant to 3 of the 4 classes of antiretroviral drugs, which means that 19 of the 20 available antiretroviral drug combinations would be ineffective for a person with this HIV strain.

Although drug-resistant HIV strains are common in patients who have been treated with antiretroviral drugs, multiple-drug-resistant HIV is extremely rare in patients who are newly diagnosed and previously untreated. Moreover, while HIV infection usually takes about 10 years to progress to AIDS, this patient apparently progressed to AIDS in a matter of months. Combination of a highly drug resistant HIV infection and rapid disease progression has the potential to become a very serious public health problem with global health implications.

The ultimate significance of the new strain is still unknown. Only time will tell whether this was an isolated case or part of an outbreak of similar cases. It is imperative, however, that we take action to identify and halt the spread of aggressive, multiresistant HIV/AIDS strains.

We must continue to build upon and fund existing prevention programs and to strengthen our infectious disease monitoring systems. The CDC, in collaboration with community, state, national, governmental and nongovernmental partners, employs a number of programs designed to prevent HIV infection and reduce the incidence of HIV-related illness and death. By providing financial and technical support for disease surveillance; risk-reduction counseling; street and community outreach; school-based education on AIDS; prevention case management; and prevention and treatment of other sexually transmitted diseases that can increase risks for HIV transmission, such programs have played a key role in reducing HIV transmission.

Stopping the spread of this strain is also critical in order to preserve the effectiveness of existing HIV/AIDS therapies. Not only do such therapies prolong and improve the quality of life of those affected by HIV/AIDS, but they also play a vital role in preventing the spread of the disease. A recent study found that HIV therapies reduce infectiousness by 60 percent. Consequently, that is why I recently reintroduced S. 311, the Early Treatment for HIV Act, ETHA. Supported by a bipartisan group of 31 Senators, ETHA redresses a fundamental flaw under the current Medicaid system that provides access to care only after individuals have developed full blown AIDS.

ETHA brings Medicaid eligibility rules in line with Federal Government guidelines on the standard of care for treating HIV. ETHA helps address the fact that increasingly, in many parts of the country, there are growing waiting lists for access to life-saving medications and limited access to comprehensive health care. Access to HIV therapies reduces the amount of HIV virus present in a person's bloodstream, viral load, a key factor in curbing infectiousness and reducing the ability to transmit HIV.

Early access to HIV therapies as provided under ETHA would not only delay disease progression and increase life expectancy, but it would also reduce the need for more expensive treatment and costly hospital stays. According to a study conducted by PricewaterhouseCoopers, ETHA would reduce gross Medicaid costs by 70 percent, saving the Federal Government approximately $1.5 billion over 10

years. With the administration looking for ways to reduce Medicaid costs, passing ETHA would be a good start. It's also the right thing to do.

SAFE GUN STORAGE SAVES LIVES

Mr. LEVIN. Mr. President, the debate on how to most effectively combat gun violence frequently centers on the ability of criminals to access dangerous firearms. Today, I would like to call my colleagues' attention to another important issue in our fight against gun violence: the ability of our teenagers and children to access firearms. Safe storage and child access prevention laws are critical steps as we seek to reduce the occurrence of accidental shootings and suicides involving guns. Such tragedies have claimed the lives of thousands of young people and destroyed families even though many of these occurrences could have been prevented by common sense legislation.

According to a Journal of the American Medical Association study released in 2001, suicide is the third-leading cause of death among youth aged 10 to 19. Between 1976 and 2001, the period of the study, nearly 40,000 youth aged 14 to 20 committed suicide using a gun. The study also found that there was a significant reduction in youth suicide rates in States that had child access prevention laws. Unlike suicide attempts using other methods, suicide attempts with guns are nearly always fatal. These children get no second chance.

The Brady Campaign to Prevent Gun Violence reported in 2004 that teenagers and children are involved in more than 10,000 accidental shootings in which close to 800 people die each year. Further, about 1,500 children age 14 and under are treated in hospital emergency rooms for unintentional firearm injuries. About 38 percent of them have injuries severe enough to require hospitalization. Blocking unsupervised access to loaded guns is the key to preventing these occurrences.

A study published last week in the Journal of the American Medical Association found that the risk of unintentional shooting or suicide by minors using a gun can be significantly reduced by adopting responsible gun safety measures. According to the study, when ammunition in the home is locked up, the risk of such injuries is reduced by 61 percent. Simply storing ammunition separately from the gun reduces such occurrences by more than 50 percent.

During the 108th Congress, I joined with 69 of my colleagues in voting for Senator BOXER's trigger lock amendment. Senator BOXER's amendment would have required that all handguns sold by a dealer come with a child safety device, such as a lock, a lock box, or technology built into the gun itself that would increase the security of the weapon while in storage. The underlying gun industry immunity bill to which this amendment was attached was later defeated in the Senate, but the need and support for this legislation is clear. In light of the bipartisan support for this trigger lock amendment during the last Congress, I am hopeful that the 109th Congress will take up and pass common sense trigger lock legislation.

While the problems of youth suicide and accidental shooting cannot be legislated away, trigger locks and other sensible gun safety measures can help limit children's access to firearms. It is clear that reducing our kids' access to guns can save lives. The time has come to support the efforts of States who have enacted common sense child access prevention laws and make responsible storage of firearms standard around the Nation.

HEALTH ACT

Mr. ENSIGN. Mr. President, last week, I reintroduced the HEALTH Act to address the national crisis our doctors, hospitals and those needing healthcare face today.

Every day, patients in Nevada and across America are losing access to healthcare services. Several states are losing medical professionals at an alarming rate, leaving thousands of patients without a healthcare provider to serve their needs.

Because of increasing medical liability insurance premiums, it is now common for obstetricians to no longer deliver babies, and for other specialists to no longer provide emergency calls or perform certain high-risk procedures.

Women's health in Nevada and elsewhere in the country is in serious jeopardy as new doctors turn away from specialties and as practicing doctors close their doors.

I have been told that one in seven fellows of the American Academy of Obstetricians and Gynecologists have stopped practicing obstetrics because of the high risk of liability claims.

When Ms. Jill Forte of Las Vegas, found out that she was pregnant with her second child, she called her doctor. The doctor told her that because of insurance costs, she could no longer deliver her baby. So Jill started calling around. She was told the same thing by five different doctors. She even considered going to California for care.

Fortunately, Ms. Forte was able to make a connection through a friend for a local doctor to take her case. She said:

> I was in total shock. I didn't know what was going on until it happened. Looking for a doctor, worried about finding a doctor when you're pregnant is a stress that is an unnecessary stress. It's a stress caused by frivolous and junk lawsuits. It doesn't make any sense to have a society that sues so often that expectant mothers are worried about finding a doctor.

Unfortunately, her story is becoming too commonplace.

Additionally, hundreds of emergency departments have closed in recent years. Emergency departments have shut down in Arizona, Florida, Mississippi, Pennsylvania, and Nevada, among others. During this same time, the number of visits to the Nation's emergency departments climbed more than 20 percent. While more Americans are seeking emergency medical care, emergency departments are losing critical staff and essential resources.

In my home State of Nevada, our only Level I trauma care center closed for 10 days in 2002, leaving every patient within 10,000 square miles unserved by a trauma unit. In fact, Ms. Mary Rasor's father died in Las Vegas last year when he could not obtain access to emergency trauma care because of the closure.

Doctors are also limiting their scope of services. More than 35 percent of neurosurgeons have altered their emergency or trauma call coverage because of the medical liability crisis. As a result, many hospitals, including Level II trauma centers, no longer have neurosurgical coverage 24 hours a day, 7 days a week. Consequently, patients with head injuries or in need of neurosurgical services must be transferred to other facilities, delaying much-needed care.

An example of this problem was recently brought to my attention by Dr. Tony Alamo of Henderson, Nevada. During his tenure as chief of staff at Sunrise Hospital, Dr. Alamo was presented with a teenager suffering from a Myasthenia Gravis crisis in need of immediate medical treatment. This condition involves shortness of breath due to muscle weakness. Such shortness of breath can become severe enough to require hospitalization for breathing support, as well as treatment for the underlying infection. If the problem is not identified and treated correctly, it could lead to death.

Dr. Alamo told me that because of the medical liability situation, there was no emergency room neurologist on call to assist this young woman. Many neurologists are afraid to become involved in difficult cases like this because of the high risks of medical liability. Consequently, Dr. Alamo had the young woman transported to California by helicopter to receive the care she needed. Because of the reasonable laws in California, neurologists aren't afraid to take call.

The bottom line is that patients cannot get the healthcare they need when they need it most. By definition, this is a medical crisis. The crisis boils down to two factors: affordability and availability of medical liability insurance for providers.

With regard to affordability, the Medical Liability Monitor found that in 2004, obstetricians in Dade County,